MODULE: 1
Understanding Alzheimer's Disease and Dementia

Alzheimer's Training for Emergency Responders
Lesson Plan

-PowerPoint

Est. length of presentation 1-2 hours

Part One - Introduction

[Slide 1 & 2] **Introduction to Topic**

[Slide 3] **Why Provide Training to Emergency Responders?**

60% of A.D. patients wander, become lost and often are seriously injured or die if not found within 24 hours.

Some A.D. patients, as a manifestation of the disease, exhibit behavioral disturbances which may endanger themselves, caregivers or responding public safety personnel.

Discussion:
You may want to ask if anyone in the class has a family member or knows someone with Alzheimer's disease.

Ask them if they'd like to share any of their experiences during the class session.

[Slide 4] **Purpose of Training**

To provide basic information about Alzheimer's disease and dementia
To identify and understand symptoms

To provide behavior patterns and typical incidents that occurs with Alzheimer's disease.

[Slide 5 & 6] **What do YOU already Know about Alzheimer's disease?**

Ask questions to class about their knowledge of Alzheimer's disease.

[Slide 7] **What is Happening to our Population? Baby Boomers**

75 million babies were born between 1946 – 1964.

In 2000, 35 million people were over the age of 65.

By 2050 over 70 million people will be over age 65; 20 million will be over 85.

In 2000, 28% of the population 65 and over lived alone in households; more than double the amount of women than men.

[Slide 8] **Average Life Expectancy**

In 1860, half the population in the U.S. was under age 20, and most were not expected to live to age 65.

[Slide 9 – 11] **Statistics**

Alzheimer's disease currently impacts an estimated 5 million people in the U.S. a largely (underestimated figure).

The number of Americans with Alzheimer's has more than doubled since 1980.

Alzheimer's disease is the 4th leading cause of death.

Alzheimer's is not just "normal" forgetfulness. Everyone forgets where he or she put their eyeglasses or their car keys. The problem becomes evident when a person forgets he wears glasses or how the car keys are to be used.

By 2050 it will be the leading cause of death among adults; 14 million Americans will have the disease.

Approximately 105,000 people have Alzheimer's disease or a related dementia in the State of Virginia.

[Slide 12 – 13] **What does Alzheimer's Disease do to a Person?**

Discuss that it affects the ENTIRE person, not just memory alone.

[Slide 14] **Alzheimer's Disease Causes Dementia. What is Dementia?**

Ask class if anyone knows what dementia is. Ask them to give examples if they can.

Part Two - Presentation

[Slide 15] **What is dementia?**

Not long ago, the term *senile* was used to describe someone who was elderly and suffering from memory loss. Over time, the term *senile* and the term *dementia* have been confused and used interchangeably. Senile literally means 'that which is aged'.

Dementia literally means 'without mind'.

Dementia is the loss of intellectual functioning such as thinking, remembering and reasoning of sufficient severity to interfere with a person's daily functioning.

It is **not** a disease in itself, but rather a group of symptoms which may accompany certain diseases or physical conditions.

[Slide 16] **Diseases/conditions that can cause dementia**

Irreversible
Alzheimer's Disease (AD)
Mini-strokes (Vascular Dementia)
Parkinson's Disease
Huntington's Disease
Pick's Disease
Fluid on the Brain (Hydrocephalus)
AIDS-Related Dementia
Alcohol-Related Dementia
Head Trauma

Discuss - not all dementia is Alzheimer's, but the characteristics and behavior can be very similar.

Reversible
Drug reactions/interactions
Emotional disturbance (Depression, Schizophrenia)
Metabolic and Endocrine Dysfunction (Thyroid)
Nutritional Loss (malnourishment, vitamin deficiencies - B12)
Tumors
Infection
Arteriosclerosis

[Slide 19] **What is Alzheimer's disease?**

A degenerative, progressive brain disorder affecting memory, thought, behavior, personality and muscle control.

It is **not** a mental illness – although behavior may at times seem similar. It is a **physical disease** that attacks and destroys brain cells.

It is the most common form of dementia.

It was first described in 1906 by Alois Alzheimer.

[Slide 20] **Side View of Brain**

Alzheimer's disease affects ALL brain functioning. It begins in the hippocampus located in the center of the brain. The hippocampus is responsible for short-term memory. Eventually, as Alzheimer's disease progresses, the temporal, parietal and frontal lobes are also affected.

The manifestations of Alzheimer's disease have been recognized since ancient times. Greek and Roman writers described symptoms similar to those that we know as AD. In the 16th century, Shakespeare wrote about old age as a time of "second childishness and mere oblivion."

[Slide 21] **Indicators of Alzheimer's Disease**

Alzheimer's disease causes abnormal structural changes in the brain called plaques and tangles. These are visible under a microscope. This is what Dr. Alois Alzheimer discovered in 1906.

[Slide 22 - 23] **Brain Images**

This PET Scan comparing a healthy brain image to a person in the late stages of Alzheimer's depicts the destruction and damage of the brain. Note the obvious shrinkage and the decreased brain activity.

[Slide 24] **Alzheimer's Disease**

Most people experience Alzheimer's disease after age 65; however people in their 40's and 50's have been diagnosed.

10% of people over the age of 65 have Alzheimer's; 49% of people over the age of 85 have the disease.

It is <u>not</u> a normal part of the aging process.

It is the <u>fourth</u> leading cause of death among adults. Death is primarily due to physiological causes. Individuals with AD become less resistant to infections and other illness, and usually die of a secondary cause such as pneumonia or influenza.

The only identified risk factors are age and family history.

Scientists are not sure what causes Alzheimer's disease. A combination of genetic predisposition, environmental toxins and other physical conditions may interact to cause AD.

With individuals who are diagnosed younger than age 65 (Early Onset), experts believe there is a defect in a single gene on chromosomes 1, 14 and 21. For some patients, genetic involvement is not very clear.

[Slide 25 - 26] **Ten Warning Signs**

Memory Loss (initially with short-term memory)

Difficulty performing familiar tasks

Problems with language

Disorientation of time and place, i.e. wandering aimlessly

Poor or decreased judgment

Problems with abstract thinking

Misplacing things

Changes in mood or behavior

Changes in personality

Loss of initiative

[Slide 27 - 29] **Stages of Alzheimer's Disease**

There are <u>three</u> basic stages of AD:

<u>Early Stage</u> - memory loss and confusion is mild becoming progressively worse.

Often the person is still driving.

<u>Middle Stage</u> - memory loss and confusion worsens and is exacerbated with increased anxiety, paranoia, and delusions.

High risk of wandering.

This is often the longest stage lasting 7 years or longer.

Late Stage - bodily functions shut down, little or no ability to communicate basic needs, person becomes bedridden and needs continuous care.

Usually lasts about 1 to 3 years.

[Slide 30] **Clues for Recognizing Persons with Alzheimer's Disease**

Identification Clues:

The most immediate and clear way to know if someone has Alzheimer's disease is to look for a bracelet or necklace with the words "Memory Impaired" inscribed on it, or for a wallet card with the same message. Some individuals may carry a Safe Return key chain or lapel pin. During an encounter, keep in mind that not all people will be wearing such identification. If the person has no paper, check for possible personal ID labels on inner or outer clothing. Individuals who are driving may have identification in the glove box of the car.

Physical Clues:

Blank Facial Expressions
A person with dementia may exhibit a blank facial expression or one inappropriate for the situation. For example, a person may smile when talking about a serious issue, or avoid eye contact. The person may appear scared, nervous, indifferent, anxious or tearful.

Inappropriate Clothing
A person with memory impairment may dress inappropriately for the season, wearing winter clothes in the summer and vice versa. The person may wear pajamas outdoors, or clothes that are mismatched or inside out. However, if a family member cares for a person, she or he may be dressed quite appropriately.

Age
Age is a factor in Alzheimer's disease. Ten percent of people over the age of 65 are affected.

Unsteady Gait
Visual-spatial problems frequently associated with the disease can cause the individual to shuffle their feet or to walk with an unsteady step. Observing gaits may help you recognize a person that needs your help.

[Slide 31] **Clues for Recognizing Persons with Alzheimer's Disease**

Psychological Clues:

Confusing/contradictory statements
A person with AD often loses the ability to understand what is heard. The disease blocks the person's ability to recognize and interpret correctly even the simplest sight and sound.

The result is confusion, which may appear as any of these signs:

- Inability to grasp and remember the current situation
- Difficulty judging the passage of time
- Agitation, withdrawal or anger
- Inability to sort out the obvious
- Disorientation about their own and other's identities and roles.

Communication Problems
Alzheimer's disease hinders an individual's communication skills. As a result, the person may have difficulty understanding the meaning of words, keeping thoughts clear, speaking logically, and following simple instructions. The memory-impaired person may say the same thing or ask the same question over and over again. The person does not repeat things to be annoying. He just may not be able to understand the officer's response. Stress and trauma will further impair concentration and communication skills.

Suffering from Delusions and Hallucinations
Delusions: Alzheimer's disease may cause a person to develop false ideas, often involving paranoia, which can originate in a misrepresentation of a real event. The person may firmly believe, in spite of obvious evidence to the contrary, that they were wronged and may persist with the delusional paranoia.

AD persons may hallucinate.
Hallucinations: Hallucinations are mistaken sensory experiences. Because AD blocks rational ordered thinking and the ability to reach accurate conclusions, a person may see, hear, or feel something incorrectly. The person could mistakenly identify an officer as an intruder entering their home.

Agitation
The disease can cause irritation and nervousness. This may cause a person to be fidgety. Officers should remember that the person is not purposely attempting to agitate others. Agitation is often simply part of the disease process.

Catastrophic Reaction
Excessive stimuli may trigger a 'catastrophic' reaction that is exhibited by increased symptoms of restlessness, pacing, agitation and anxiety. The individual may break down crying when confronted by an authority figure. In extreme cases, the person may become aggressive and lash out verbally and physically at anyone who is trying to help.
If a catastrophic reaction occurs, the officer must remain calm, move slowly, and indicate actions in advance. If possible, avoid any physical contact that may seem like a restraint to the person.

Forgetful
Often a person with Alzheimer's will experience short-term memory loss, while memories from the past may be intact.

Forgetfulness may come and go, sometimes within minutes. Because of memory loss, the person may appear uncooperative, especially when answering questions about the present or very recent past. The person may also remember a former address and provide this as their current address.

Disoriented/Lost

It is common for individuals with AD to become disoriented and lose their way even in familiar surroundings.

Impaired judgment and reasoning skills

People in the initial stages of AD think less clearly and tend to be easily confused.

[Slide 32] **Commonly Prescribed Treatments**

The FDA approved the first treatment for Alzheimer's disease, tacrine (Cognex®), in 1993. Since then, researchers have made great strides in developing better medications for the treatment of Alzheimer's disease. The first four treatments, Cognex, Aricept, Exelon, and Reminyl (recently renamed Razadyne) are known as c*holinesterase inhibitors*. These medications are designed to enhance memory and other cognitive functions by influencing certain chemical activities in the brain.

Many people are prescribed these medications along with an anti-depressant. Some are also prescribed anti-psychotic and/or sleeping medications.

It should be noted that these treatments are designed to treat only the symptoms of Alzheimer's disease and stimulate certain chemicals to keep the brain functioning at the highest level possible. These do not aid in stopping or preventing the destruction of brain cells; therefore cognitive functioning and changes in the brain are still occurring. After a certain point in the progression of this disease, the medications are often no longer effective.

Memantine (Namenda®), the latest drug to be approved, may protect against the destruction and death of brain cells by controlling the amount of calcium absorbed into nerve cells. Calcium is necessary to create an environment required for information storage in the nerve cells. However, an excess of calcium will create a reverse effect and destroy brain cells. This is the first drug of this type approved in the United States.

MODULE: 2
Understanding Difficult Behaviors

[Slide 34] **Common Problem Behaviors**

Repetition: Due to memory loss, the person repeats the same questions, statements, or stories.
Examples:

- Asking what time it is, over and over and over.
- The same joke, not remembering that it was just told a few minutes ago.
- Buttoning and unbuttoning his/her shirt over and over
- Folding and refolding papers

Loss of Inhibition (Social Norms): Sexual activity involving inappropriate language, public exposure, and offensive and /or misunderstood gestures.
Examples:

- Urinating on the flowers in the parking lot
- Touching self inappropriately
- Using 'wrong' words in conversation (cursing)

Rummaging, Hiding, and Hoarding: This behavior involves compulsive behavior to search for, collect and hide things.
Examples:

- Stashing boxes of Kleenex around the house, hiding money
- Excessive collecting of pets (cats, dogs etc...)
- Saving bags of trash, old cartons, newspapers, magazines, money

Pacing/Fidgeting: constantly moving even while seated, cannot control motor activity.
Examples:

- Walking back and forth, even in a small space
- Swaying back and forth, unable to stop
- Inappropriate behavior performed too frequently

Sundowning: Behavior associated with Alzheimer's disease that causes an individual to become restless, agitated, more confused and insecure late in the day or very early in the morning.
Examples:

- At 3:00 p.m., AD individual wants to 'go home' despite the fact she is in her home of 30 years.
- Awakes from a nap and starts looking for the door to get out of the house.
- Leaves the home and wanders off and becomes lost

Wandering: To move about with or without a destination/purpose; to go astray or be lost
Examples:

- AD individual is at the mall with family. She walks away to window shop and cannot retrace her steps to find the family. She is lost.
- At 3:30 p.m. everyday 70-year-old Julia tries to get out of the home to pick up her 6-year-old daughter from school.

Ask class to share their experiences

Annie drives to the grocery store, gets her groceries, and then cannot find her way home. She drives for two days.

[Slide 36 - 37] **Calls for Emergency Services: Driving**

It is VERY difficult to convince a person to stop driving

Common Dangers:

Difficulty Staying Alert
Missing traffic signals or road signs
Becoming Disoriented/Distracted
Running out of Gas

Faulty Judgment

Problems exiting/merging into traffic
Over-reacting
Driving on the wrong side of the road

Delayed Reaction Time

Noticing changing stoplights too late
Braking too late to avoid collision

Interventions:

DMV Medical Review Form
Family Physician
Disabling/Selling Vehicle

[Slide 38] **Calls for Emergency Services: False Reports**

False Reports to 911

Someone is stealing money or items
Seeing people or animals
Reporting intruders/strangers

Interventions:

Don't argue
Respond to their fear and anxiety
Consider contacting family or Social Services

[Slide 39 - 40] **Calls for Emergency Services: Domestic Violence**

Domestic Violence

Aggression often caused by:

Mistaken Identity
Confusion
Over-stimulation, i.e., noisy environment
No pre-meditation

Code of Virginia: Section **19.2-81.3B**

An officer shall arrest . . . unless there are special circumstances that dictate action other than arrest.

Paragraph C states that if an arrest isn't made, officers must file a written report indicting why and the circumstances.

Most agencies have a policy that states an arrest must be made.

Alternatives to Arrest: TDO/Psychiatric Evaluation

[Slide 41] **Calls for Emergency Services: Homicide/Suicide**

Homicide and Suicide

- Some premeditation particularly for early onset or very soon after diagnosis
- Many caregivers consider at some point

[Slide 42] **Calls for Emergency Services: Indecent Exposure/Shoplifting**

Indecent Exposure

Accidental resulting from either:

- Loss of inhibitions (social norms)
- Inability to dress themselves properly

Shoplifting

- No intent – forget to pay

[Slide 43] **Calls for Emergency Services: Abuse and Neglect**

Abuse/neglect

- Can occur on behalf of either party
  - Often difficult to ascertain whether person with Alzheimer's is truly suffering or paranoid
- Social Services (APS) should be called for investigation

[Slide 44] **Calls for Emergency Services: Poisoning/Choking/Falls**

Poisoning/choking

- May ingest toxic chemicals, i.e. shampoo, cleaning materials
- May overdose on medication

Falls/tripping

- Stairs and shower stalls

[Slide 45] **Calls for Emergency Services: Burns/Fires/Trespassing**

Burns/electrocution

Loss of sensitivity to hot/cold

Accidental Fire

Cooking, microwave, space heaters, smoking

Trespassing

Wandering

[Slide 46] **Assessing the Individual**

Remind class that assessing the individual will vary depending on which stage of the disease the person is in.

Rely on caregiver for information

Do not separate the caregiver from patient

Allow caregiver to be transported with patient

Patient may become combative due to environment

Sometimes patient may respond better to one person than another

[Slide 47] **Communicating**

The basic underlying feeling that AD persons have is **fear**. AD persons will be afraid of you and not recognize your uniform. It is important that you try to help them understand that you are there to help them - not hurt them.

Approach from the front; introduce yourself

Making eye contact improves communication.

Tell them you are there to help them

Identify yourself and tell the person that you are there to help.

Speak slowly and calmly; do not raise your voice

Speak slowly, calmly, and in a non-threatening tone. A *lower* tone of voice works best. Avoid shouting.

Allow ample time to respond

Ask only one question at a time

Ask simple questions. Use short familiar words and simple sentences.

Asking ‘yes’ and ‘no’ questions generally is the best approach. Keep

explanations simple.

Keep the climate calm

Remove the person from a noisy or stressful situation. Don’t crowd the person’s personal space. Step back and give them some room.

Keep instructions positive

Provide positive reassurance. The person will not be able to process lengthy description of your course of help.

Substitute non-verbal for verbal communication

Body language is very helpful. Motioning and pointing with your hands helps the individual understand what is expected of them.

Avoid restraints if possible

Restraints can elicit a catastrophic reaction, however it is important to maintain the safety of the individual, others in the area and the officer. If restraining the person is an unavoidable, practice techniques for preventing injury.

MODULE: 3
Major Resources in the Community

Information about the following programs is located in the Resource Section of this manual.

-PowerPoint

Est. length of presentation 30 – 60 minutes.

Representatives from the Alzheimer's Association chapter and Project Lifesaver International can be called in to explain local resources.

[Slide 48] **Additional Resources**

Alzheimer's Association Area Chapters provide many resources to families including information and referral and support groups. Many families are unaware that a resource such as the Alzheimer's Association exists. It is important to remember to refer family members to the Alzheimer's Association so that they can get information to better deal with their situation.

Greater Richmond Chapter
4600 Cox Road, Ste. 130
Glen Allen, VA 23060
(804) 967-2580/(800) 598-4673

Southeastern Virginia Chapter
#20 Interstate Corporate Center, Ste. 233
Norfolk, VA 23502
(757) 459-2405/(800) 755-1129

Central and Western Virginia Chapter
1807 Seminole Trail, Suite 204
Charlottesville, VA 22901
(804) 973-6122/(888) 809-7383

National Capital Area Chapter
11240 Waples Mill Road, Ste. 402
Fairfax, VA 22030
(703) 359-4440/(866) 259-0042

Alzheimer's Association Safe Return Program

Safe Return is a nationwide identification, support and registration program funded by the Department of Justice, working at the community level. Safe Return provides 24-hour assistance whenever a registrant is missing or found.

When a registrant is **missing**, Safe Return faxes the person's information and photo to the local law enforcement agency. When a registrant is **found**, citizens or law enforcement official can call the 800 number on the identification products (Safe Return bracelet, necklace, and/or iron-on clothing labels). Safe Return can access registrant information immediately and notify listed contacts.

The number for the Safe Return Program to report someone **missing or found** is 800-572-1122.

If you find someone who has wandered away from home, you should refer the family to their local Alzheimer's Association Chapter to request an ID bracelet through the Safe Return Program.

Project Lifesaver International

State of the art transmitter system worn by an individual with AD

Monitored by specially trained search and rescue personnel usually operated through a local law enforcement and/or sheriff's office

All programs are coordinated through Project Lifesaver International

Contact Information:

Project Lifesaver International

815 Battlefield Blvd. S.
Chesapeake, VA 23322
(757) 546-5502
www.projectlifesaver.org

State Search and Rescue Resources

State resources are provided without cost to locality

State resources have state provided workman's compensation and liability

To obtain state resources call the Virginia Department of Emergency Services at (800) 468-8892.

[Slide 50] **For Additional Information regarding training contact:**

Commonwealth of Virginia
Alzheimer's Training Program for Emergency Service Personnel
Julie Ana Skone
Dept. of Criminal Justice Services
(757) 692-0108

MODULE: 4
Wandering and Becoming Lost

-PowerPoint

Est. length of presentation 30 – 60 minutes

Searching for a Missing Alzheimer's Person

Introduction

Most people can access the skill of "cognitive mapping," the ability to find their way from one point to another. For example: Most of you know where your car is even though you cannot see it from this room. However, people with Alzheimer's experience impaired cognitive mapping *very early in the disease process*. Damage to the specialized parts of the brain engaged in spatial orientation hinders an AD person's ability to retrace their steps, even in familiar environments, thus increasing the risk of becoming lost.

Memory-impaired individuals can be lost while shopping, driving, walking to the bus stop, or walking the family dog around the neighborhood. Most often, these adults will keep trying to 'find their way' on their own. Typically, they do not ask for help. This can complicate their situation as they become more and more stressed. Each year the number of reported cases increase. Some people are found quickly, while others remain lost for days, weeks, even months. In too many cases, the person is never recovered, or deceased when recovered.

Wandering

Wandering is one of the most common, potentially life threatening behaviors associated with Alzheimer's disease. Wandering involves leaving a safe environment or intruding into inappropriate places or walking away and getting lost. Wanderers are individuals who are displaced from their appropriate surroundings.

Wandering may not have a meaningful pattern, *or* it may be purposeful in a direct path. There is no way to predict who will wander, when or how. Regardless of how or why a memory-impaired person wanders, this behavior can be life threatening and requires an immediate response.

Wandering in the truest definition of the word, involves the mid and later stages of the disease.

Ask class to share their own experiences.

[Slide 52] **Searching for a Missing Alzheimer's Person**

The Wandering Problem:

For every 1,000 people in Virginia, 15 suffer from Alzheimer's disease.
•**18%** of those with mild dementia, *wander*
•**50%** of those with severe dementia, *wander*

[Slide 53] **The Wandering Problem**

1% of lost Alzheimer wandering incidents reported to law enforcement result in fatalities.
One-third of those incidents where the lost person is not located within 24 hours results in fatalities.

[Slide 54] **Subject's Profile**

•Leaves residence or nursing home
•Has a previous history of wandering
•May cross or depart from roads (67%)
•Usually (89%) found within one mile of place last seen
•Usually found a short distance from road (off road)
•Attempts to travel to former residence

[Slide 55] **Subject's Profile**

•Leaves few verifiable clues
•Will not cry out for help or respond to shouts
•Usually found in a creek, drainage area, brush or briars (47%)
•Succumbs to the environment

[Slide 56] **Behavioral Hypothesis**

Why do they get lost?

•Wandering Initiated
    Agitation (exit seekers, escapist, want to go home)
    Depression, goal oriented
•Becomes Lost
    Loss of time, short term memory, spatial mapping
•Intense Emotional Crisis
    Panic reaction

[Slide 57] **Alzheimer's vs. Navigation**

If you can't recognize where you are for lack of landmarks, can't judge how far back to where you came from and don't know how to turn around, you get lost.

[Slide 58] **Search is an Emergency**

•Subject needs emergency care.
•Subject needs protection from weather and self.
•Time and weather destroy clues.
•Urgent response decreases search difficulty.
•Search size grows exponentially with time.
•Subject seldom 'walks' out.

Caregiver's often wait hours before calling for help once they notice their loved one is missing.

[Slide 59] **Search is an Emergency**

•No deaths when subject found within 12 hours of the time last seen.
•If subject found DOA, average time to contact SAR = 50 hours.
•If subject found uninjured, average time to contact SAR= 12.3 hours.
•Subjects die due to environment.

[Slide 60] **Search at Night**

•Subject does not generally move at night.
•Searchers / dogs are able to hear better at night.
•Air-scent dogs work better at night.
•Bloodhounds may work better at night.
•25% of finds occur at night

[Slide 61] **Distance Traveled**

(Distances given in *crow's flight*.)
Average distance: 0.6 miles.
50% subjects found within: 0.5 miles.
75% subjects found within: 0.7 miles.
94% subjects found within: 1.5 miles.
Individuals with severe dementia travel shorter distances.
Wanderers who stay on roads go further.

[Slide 62] **Contact Trained S.A.R. Resources**

Bloodhounds
Air-scent dogs
Helicopters
Fixed wing aircrafts
Search management
Man trackers
Field team leaders
Field team members
Mounted (horse) SAR teams
Bike teams
Other specialized SAR resources

To obtain state resources call the Virginia Department of Emergency Services at (800) 468-8892.

[Slide 63] **Planning Data**

Point Last Seen (PLS)
Last Known Position (LKP)
Circumstances surrounding loss
Initial actions taken by caller
History of the missing subject
Physical and mental health of subject
Personality traits
Weather, terrain, hobbies or activities person used to engage in

[Slide 64] **Find Environment**

•General pattern: They go until they get stuck.
•Unique in the tendency to go into brush/ briars.
•Requires searching off roads.
•Many subjects found near or in creeks or drainage ditches.
•Many nursing home cases where subject was found within the structure, make sure staff checks every room, even if the door is locked.

[Slide 65] **Resources**

Once the subject is located, **please** remember to refer family members to resources such as the Alzheimer's Association, Safe Return or Project Lifesaver. Many of them are unaware that such resources exist.

(refer to Module 3 for a listing of phone numbers and contact information).

MODULE: 5
The Alzheimer's Association Safe Return Program
PowerPoint Presentation
Jane Priest, LPN
Alzheimer's Association National Capitol Area Chapter

MODULE: 6

Lesson Plan Outline Example for 3-4 Hour Block of Training

Investigator J. M. Berger
Henrico Police Department

MODULE: 7
First Responder Training
Scenarios for Role Playing

MODULE: 8

Dealing with Alzheimer's Disease Inside the Jail Environment

Diane Purks, R.N., C.J.M., C.C.H.P.
Health Services Administrator
Peumansend Creek Regional Jail

MODULE: 9
Search Management and Case Studies